PRINTED: 08/01/2011 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES					1B NO. 0938-0391
STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	(X3) DATE SURVEY		
and plan of correction identification number: 155321		IDENTIFICATION NUMBER:	A DITE	LDING	01	COMPLETED	
		B. WIN			06/24/2011		
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			AST STATE BOULEVARD		
MULED				1			
WILLER	S MERRY MANOR			FORT	WAYNE, IN46815		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000			i				
	A Life Safety C	ode Recertification	l K	0000			
	· ·	nsure Survey was					
		•					
	· ·	the Indiana State					
	Department of	Health in					
	accordance wit	th 42 CFR 483.70(a).					
	Survey Date: 0	06/24/11					
	Julvey Date. C	70/24/11					
	Facility Number: 000214						
	Provider Number: 155321						
	AIM Number: 100267240						
	7 100207210						
	Surveyor: Amy Kelley, Life Safety						
	Code Specialist						
	At this Life Safety Code survey,						
	Miller's Merry Manor was found						
	·						
	not in compliance with						
	Requirements for Participation in						
	Medicare/Medicaid, 42 CFR						
	Subpart 483.70(a), Life Safety						
	from Fire and the 2000 edition of						
	the National Fire Protection						
	Association (NFPA) 101, Life Safety						
	Code (LSC), Chapter 19, Existing						
	Health Care Occupancies and 410						
	IAC 16.2.						
	, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,						
	This one story	•					
	walkout lower level was						
	determined to	be of Type II (111)					
			1				1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MAAU21

Facility ID:

000214

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155321		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/24/2011			
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5544 EAST STATE BOULEVARD FORT WAYNE, IN46815					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	alarm system we detection in the areas open to to facility has a call had a census of this survey.  Quality Review by I Code Specialist-Med  The facility was compliance with aforementioned.	ne facility has a fire with smoke e corridors and he corridors. The pacity of 77 and f 60 at the time of Robert Booher, Life Safety dical Surveyor on 07/01/11.						
K0056 SS=E	installed in accord Standard for the Ir Systems, to provio portions of the buil properly maintaine 25, Standard for th Maintenance of W Systems. It is fully reliable, adequate system. Required equipped with wat	vation and	K00	056	Please accept this plan of correction as our credible		07/24/2011	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155321		Ì	LDING	NSTRUCTION  01	(X3) DATE SURVEY COMPLETED 06/24/2011			
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE  5544 EAST STATE BOULEVARD  FORT WAYNE, IN46815					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	REFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	4 of 4 resident constructed ba closets on the accordance with Standard for the Sprinkler System complete cover of the building practice could sixteen resident Findings include Based on an obtaintenance D 06/24/11 at 20 renovation production and a closet we resident rooms (still under continuation of these relacked sprinkled was acknowled)	m was provided for rooms with newly throoms and 100 hall in h NFPA 13, e Installation of ms, to provide rage for all portions. This deficient affect three of its on the 100 hall. The irector on 00 p.m., during the cess a bathroom ere added to 102, 112, 115 struction) and 116. and the closet in esident rooms r coverage. This ged by the irector at the time			allegation of compliance: K Safe Care has been contacte and sprinklers will be installe each bathroom and closet to meet regulations in rooms 10 112, 115, and 116 by July 24 2011. All residents residing of 100 Unit could have been at for this deficient practice. The tool titled "Life Safety Review (Attachment A) will be compl weekly x 4 weeks, then monthly by the facility Maintenance Director to ensi sprinklers are added to all ne constructed rooms. Correcti action will be complete by 2 24, 2011.	ed d in  02, th, on risk e QA v" eted  ure ewly ve		

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155321		LDING	ONSTRUCTION  01	(X3) DATE ( COMPL 06/24/2	ETED	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE  5544 EAST STATE BOULEVARD  FORT WAYNE, IN46815					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		Έ	(X5) COMPLETION DATE	
K0069 SS=E	Cooking facilities a with 9.2.3. 19.3. Based on obser interview, the frensure the baff kitchen exhaus installed correct Edition, Standa Control and Fir Commercial Co 3–2.5 states fill installed at an a 45 degrees from This deficient pany resident, state kitchen.  Finding include Based on obser Maintenance Di 06/24/11 at 12 baffle filters in hood were align the kitchen ran system prevent other material in the trough for installed and the sitchen ran system prevent other material in the trough for installed and the sitchen for installed and the sitchen ran system prevent other material in the trough for installed and the sitchen for installed and the sitchen ran system prevent other material in the trough for installed and the sitchen for installed and the sitchen ran system prevent other material in the trough for installed and the sitchen for installed and the sitchen ran system prevent other material in the sitchen for installed and the sitchen ran system prevent other material in the sitchen for installed and the sitchen ran system prevent other material installed and the sitchen for installed and the sitchen ran system prevent other material installed and the sitchen for installed and the sitchen ran system prevent other material installed and the sitchen ran system prevent other material installed and the sitchen ran system prevent other material installed and the sitchen ran system prevent other material installed and the sitchen ran system prevent other material system.	are protected in accordance 2.6, NFPA 96 vation and acility failed to defilters in 1 of 1 t systems were atly. NFPA 96,1998 and for Ventilation e Protection of toking Operations, ters shall be angle not less than and the horizontal. Oractice could affect aff or visitor near action on 2:40 p.m., the the kitchen range ned horizontally in ge hood exhaust ing the grease and from dripping into removal. This was by the Maintenance	K	0069	K069 The baffle filters in the kitchen range hood have bee corrected to meet regulations residents in this facility could been at risk for this deficient practice. The QA tool titled "I Safety Review" (Attachment A) will be completed weekly weeks, then monthly by the facility Maintenance Director ensure proper placement and functioning of baffle filters. Corrective action will be complete by July 24, 2011.	s. All have Life x 4	07/24/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155321 06/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5544 EAST STATE BOULEVARD MILLER'S MERRY MANOR FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Medical gas storage and administration areas K0076 are protected in accordance with NFPA 99. SS=E Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 K0076 K076 The liquid oxygen unit was 07/24/2011 Based on observation and removed immediately from the interview, the facility failed to unit and moved to the oxygen ensure 1 of 2 liquid oxygen storage unit outside. All residents storage areas was separated by could have been at risk for this deficient practice. All nursing staff construction with a one hour fire was inserviced on 7/15/11 on the resistant rating. NFPA 99, policy titled "Compressed Gas 8-3.1.11.1 requires storage for Plan" (Attachment B). This policy covers the handling, storage, and nonflammable gases shall comply utilization of compressed with 4-3.1.2. NFPA 99, gases. The QA tool titled "Life 4-3.1.1.2(a)requires at least one Safety Review" (Attachment A) hour fire resistant enclosures shall will be completed weekly x 4 weeks, then monthly by the be provided for the storage of facility Maintenance Director to oxidizing agents such as oxygen. ensure proper storage of oxygen. This deficient practice could affect Corrective action will be any of the sixteen residents on the complete by July 24, 2011. 100 hall. Findings include: Based on an observation with the Maintenance Director on 06/24/11 at 12:30 p.m., a stationary liquid oxygen unit was

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AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155321	(X2) M A. BUII B. WIN	LDING	NSTRUCTION  01	(X3) DATE S COMPL <b>06/24/2</b> (	ETED			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE						
MILLER'S MERRY MANOR				1	AST STATE BOULEVARD VAYNE, IN46815					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE			
	100 hall near t At 2:03 p.m. th oxygen unit wa near the 100 h Based on interv Maintenance D not explain wh unit was stored Based on interv Director of Nur she stated the was empty. Th	as in the corridor all nurses' station. view with the irector, he could y the liquid oxygen d in the corridor. view with the esing at this time, liquid oxygen unit ne Maintenance red the liquid d placed it in the								